

Trends

Figure 1. The decline in malaria since 1940 has been rapid. In spite of the influx of new cases in military personnel who served in Korea, the number of malaria cases reported in 1951 was well below the levels of 1940 or 1945. However, the number reported in 1951 was larger than in 1950. In addition to anti-malarial measures in many States, the concept that a definite diagnosis of malaria can only be made following a laboratory examination of blood smears has tended to eliminate many who previously would have been counted as malaria cases. Careful follow-up in many States indicates that new cases of indigenous malaria are now uncommon. Under intensive study, the effect of the importation of Korean malaria, beyond an added number of cases, is not known but is probably small.

Figure 2. The incidence of endemic typhus fever, which has occurred principally in southeastern United States, has decreased. The lower incidence shown for 1951 undoubtedly has resulted from control measures applied on a fairly extensive scale in a number of States.

Figure 3. Prior to 1925, scarlet fever was a dreaded disease of childhood, and its relationship to other streptococcal infections of the throat was not recognized. In the past 25 years the number of reported cases of scarlet fever declined steadily except for the years 1943, 1945, and 1946. On the other hand, the number of reported cases of septic sore throat has increased in the past decade. Part of this increase probably has resulted from the fact that scarlet fever cases are now so mild that a diagnosis of septic throat is more descriptive of many infections.

The National Office of Vital Statistics of the Public Health Service has prepared this section.

MALARIA

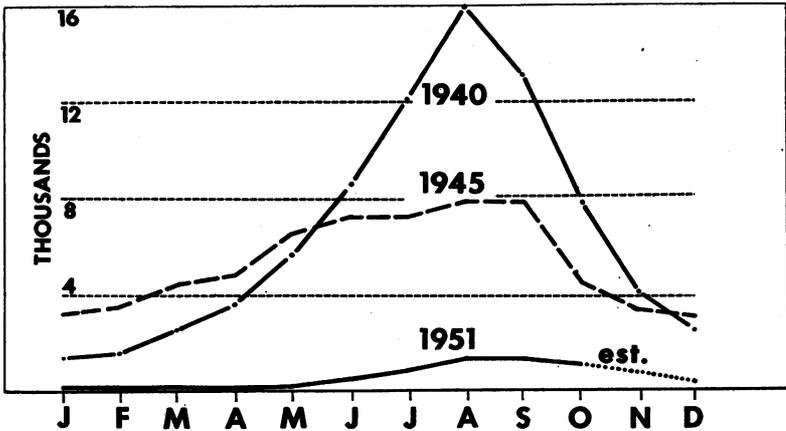


Figure 1. Malaria cases reported by months.

TYPHUS FEVER

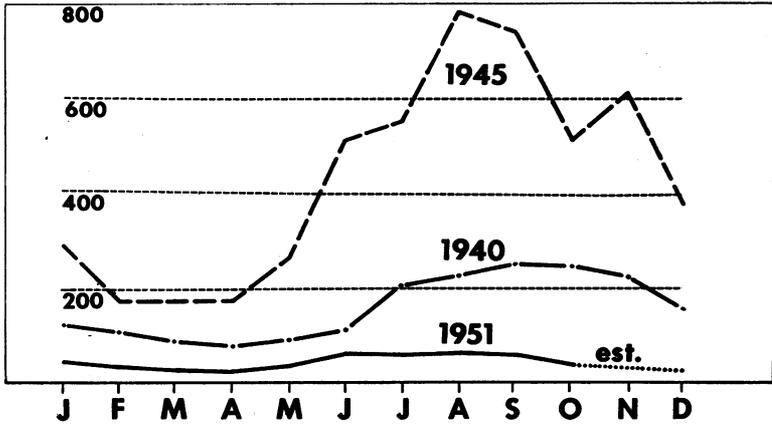


Figure 2. Endemic typhus fever cases reported by months.

SCARLET FEVER and SEPTIC SORE THROAT

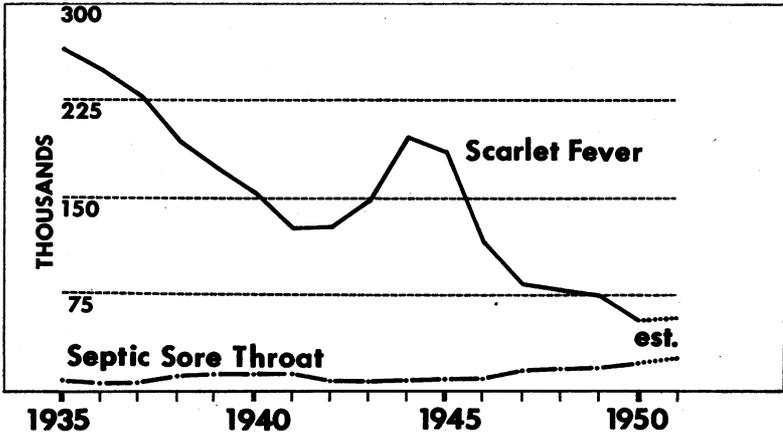
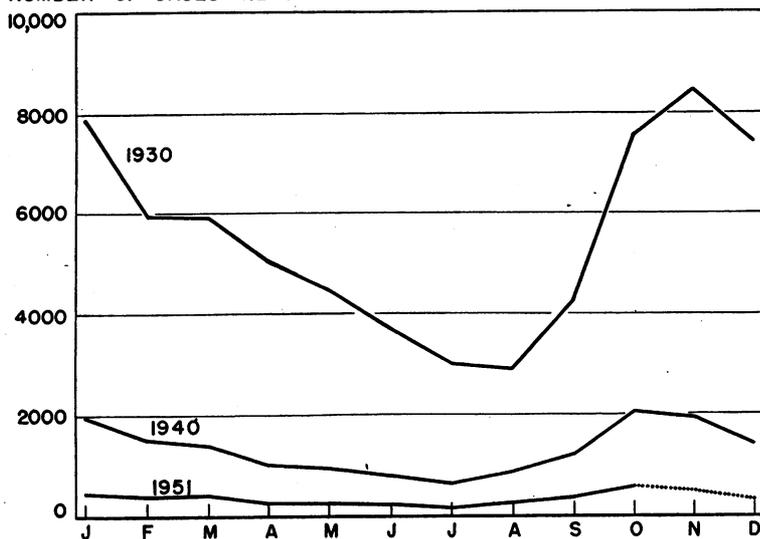


Figure 3. Scarlet fever and streptococcal sore throat by years.

DIPHTHERIA

NUMBER OF CASES REPORTED



RATE PER 100,000 POPULATION

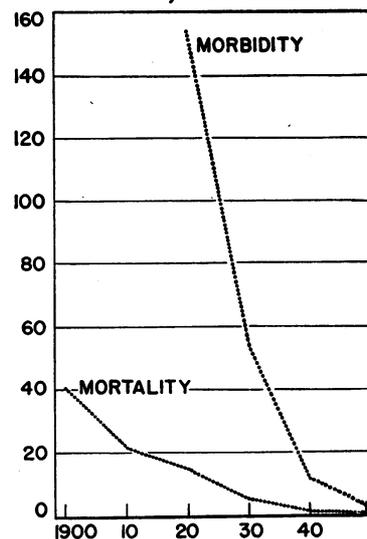


Figure 4. Diphtheria morbidity and mortality: United States.

Figure 4. The marked change in incidence of diphtheria in the United States since 1920 is shown in the two graphs. The sharp seasonal rise in the fall months has al-

most disappeared and the minor upswing is due principally to a relatively high incidence in the southeastern part of the country. In other sections, incidence remains

at a low level without the usual sharp rise in October, November, and December. Both morbidity and mortality have shown the same rate of decline to remarkably low levels.

TYPHOID and PARATYPHOID FEVER

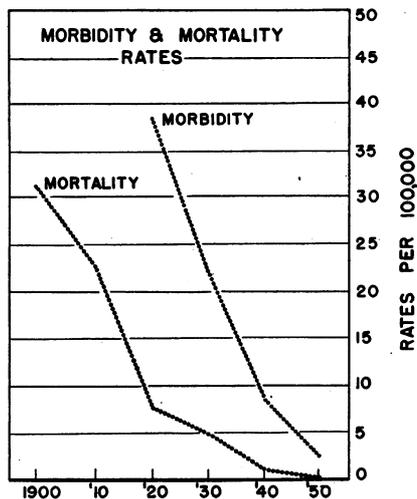
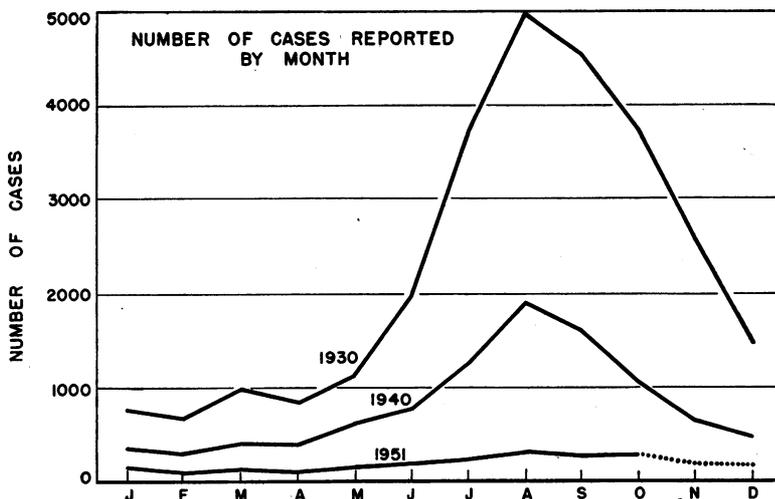


Figure 5. Typhoid and paratyphoid fever morbidity and mortality: United States.

Figure 5. The reported incidence of typhoid and paratyphoid fever, principally the former, has declined to very low levels. The usual summer peak of cases is almost non-

existent. Typhoid fever occurrence in various parts of the country is at such a low level that the disease no longer can be used as an index of sanitary conditions. Also,

typhoid fever morbidity and mortality have declined at the same rate. This indicates that the disease has not become less severe over the past few decades.